FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____ COLLEGE ATTENDING _____

UCONN HEALTH

AETNA HEALTH PROFESSIONS PARTNERSHIP INITIATIVE

PRE COLLEGE ACADEMIC ENRICHMENT PROGRAM

WEBSITE: HEALTH.UCONN.EDU/HCOP/

SPONSORED BY:
HEALTH CAREER OPPORTUNITY PROGRAMS
UCONN HEALTH
FARMINGTON, CT 06030-3920

INSTRUCTIONS TO APPLICANTS (TO ASSIST IN APPLYING FOR ADMISSION)

1. APPLICATION MUST BE RECEIVED BY THE HCOP OFFICE NO LATER THAN MAY 1
2. APPLICATIONS ARE CONSIDERED BY THE ADMISSIONS COMMITTEE WHEN THEY ARE COMPLETE. APPLICANTS SHOULD UNDERSTAND THAT IT IS THEIR RESPONSIBILITY TO SUBMIT ALL MATERIAL, INCLUDING RECOMMENDATION LETTERS.
3. AFTER RECEIPT AND REVIEW OF APPLICATIONS, THE ADMISSIONS COMMITTEE WILL CONTACT THE PROSPECTIVE PROGRAM PARTICIPANT. ***PRIORITY CONSIDERATION WILL BE GIVEN TO PIPELINE PARTICIPANTS.***

APPLICATIONS CONSIST OF THE FOLLOWING

1. A COMPLETED APPLICATION FOR ADMISSION WITH ESSAY
2. OFFICIAL SCHOOL TRANSCRIPT(S) – ALL ACADEMIC SCHOOL YEARS
3. TWO (2) RECOMMENDATIONS (PREFERABLY FROM A SCIENCE INSTRUCTOR)
4. OFFICIAL COPY OF YOUR SAT AND/OR ACT SCORE REPORT
5. A COPY OF THE LATEST FEDERAL INCOME TAX FORM 1040 OR EQUIVALENT ON WHICH YOU ARE CLAIMED AS A DEPDENDENT (SUBMIT WHEN COMPLETED AND FILED)

FOR OFFICE USE ONLY

DATE RECEIVED _____ COMPUTER ENTRY _____

For additional information, contact:

Granville Wrensford, Ph.D.
Health Career Opportunity Programs
UConn Health
263 Farmington Ave.
Farmington, CT 06030-3920
860-679-8031
gwrensford@uchc.edu

Kerry-Ann Stewart, Ph.D.
Health Career Opportunity Programs
UConn Health
263 Farmington Ave.
Farmington, CT 06030-3920
860-679-3926
kestewart@uchc.edu

TO BE COMPLETED BY STUDENT APPLICANT

PLEASE CHECK THE PROGRAM TO WHICH YOU ARE APPLYING:

PRE COLLEGE ACADEMIC ENRICHMENT PROGRAM *(SEE WEBSITE FOR DETAILS)*

☐ UCONN, STORRS ☐ CCSU

HAVE YOU PREVIOUSLY PARTICIPATED IN THE HEALTH CAREER DISCOVERY PROGRAM (CPEP), GREAT EXPLORATIONS PROGRAM, JUMPSTART PROGRAM, JUNIOR DOCTORS ACADEMY, SENIOR DOCTORS ACADEMY, SPORT & MEDICAL SCIENCES ACADEMY EPIDEMIOLOGY COURSE, SPORT & MEDICAL SCIENCES ACADEMY COLLEGE SCIENCE PARTNERSHIP SERIES, HIGH SCHOOL MINI MEDICAL/DENTAL SCHOOL PROGRAM OR HIGH SCHOOL STUDENT RESEARCH APPRENTICE PROGRAM?

☐ YES ☐ NO IF YES, INDICATE THE PROGRAM(S) IN WHICH YOU HAVE PARTICIPATED AND THE YEAR(S):

_____

_____

_____

CAREER INTEREST: ☐ MEDICINE ☐ DENTAL MEDICINE ☐ BIOMEDICAL RESEARCH/PHD ☐ NURSING ☐ PHARMACY ☐ PUBLIC HEALTH
☐ ALLIED HEALTH (SPECIFY)_____ ☐ OTHER (SPECIFY) _____

First Name | Middle Name | Last Name | College Attending

Personal information (please type or print clearly)
(all questions in this section must be answered completely)

1. Name: First Name Middle Name Last Name

Date of Birth: Age: Social Security Number:

City and State of Birth:

Citizenship: ☐ USA ☐ Permanent Resident ☐ Other (specify)

2. Legal Residence:
Street/Apartment/PO Box

City State Zip Code

Area Code/Telephone Number Cell Phone Number

3. E-Mail address (most frequently used and checked)

4. Last Day school for academic year:

Family Information (all questions in this section must be answered completely)

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Black/African American ☐ Caucasian ☐ Native American/Alaskan ☐ Mexican American/Chicano ☐ Puerto Rican
☐ Asian (specify) ☐ Native Hawaiian/Pacific Islander
☐ Other (specify)

Family Taxable Income : Family Size (Total Number of Exemptions Claimed):
(Info per Federal Form 1040 or Equivalent on which you are claimed as a dependent)

Father: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name: Occupation:

Education: ☐ Less Than/Partial High School ☐ High School Graduate ☐ Some College ☐ Associates Degree
☐ BA/BS Degree ☐ Graduate School ☐ Professional School (specify)

Mother: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name: Occupation:

Education: ☐ Less Than/Partial High School ☐ High School Graduate ☐ Some College ☐ Associates Degree
☐ BA/BS Degree ☐ Graduate School ☐ Professional School (specify)

A copy of the latest Federal Income Tax Form 1040 or Equivalent on which you are claimed as a dependent is required
(submit when completed and filed)

List in chronological order all schools you have attended

Institution	City	Dates Attended

Indicate high school currently attending:

Overall GPA: Science GPA:

Test Scores:
SAT: Total Critical Reading Mathematics Writing Skills
ACT: Composite Score English Math Reading Science Writing
GRE: Analytical Writing Verbal Quantitative

First Name Middle Name Last Name College Attending

List honors received (including honor societies)

List extracurricular and community activities

List any research experience

List any health related activities

Employment experience: (full/part time)

Employer Length of Employment

Have you had computer training: ☐Yes ☐No

List science and mathematics courses you expect to complete this school year:

Fall Semester		Spring Semester	
Course Title	Course Credit	Course Title	Course Credit

College major:

Permission for student to participate in the Aetna Health Professions Partnership Initiative Summer Enrichment Programs

I hereby consent/give my permission to participate in the Aetna Health Professions Partnership Initiative programs. I understand that participation includes attendance at all sessions of the required activities outlined in program descriptions & I further understand that there will also be participation in field trips & other activities away from the site. I will/give permission to attend these functions & to be transported by approved buses unless I give written withdrawal of permission for a specific event. The Department of Health Career Opportunity Programs is given permission to reproduce for publications & internet use any photos taken at program functions.

Applicant Signature Date

Parent/Guardian Signature Date

(please sign if you are a parent or guardian of an applicant under eighteen years of age)

Federal Family Educational Rights and Privacy Act

I hereby consent to the disclosure of student information records maintained by the Department of Health Career Opportunity Programs &/or the public schools. This information will be maintained in a confidential manner & will be used only for the purposes of the HCOP evaluation. Use is consistent with the Federal Family Educational Rights & Privacy Act of 1974, or other state or federal laws, regulations, or policies. I understand that this permission may be withdrawn at any time. The Department of Health Career Opportunity Programs is given permission to reproduce for publications & internet use any photos taken of myself or my child at program functions.

Applicant Signature Date

Parent/Guardian Signature Date

(please sign if you are a parent or guardian of an applicant under eighteen years of age)

First Name | Middle Name | Last Name | College Attending

FOR HIGH SCHOOL AND COLLEGE STUDENTS

Have you ever been dismissed, disqualified, suspended, on probation, or subject to disciplinary action at any high school or college/university in connection with your academic performance? ☐Yes ☐No

If yes, on a separate sheet of paper, explain the action including: 1) brief description of incident 2) specific charge(s) 3) disciplinary action taken 4) how the experience affected your life

Have you ever been dismissed, expelled, violated an honor code, disqualified, suspended, on probation, or subject to disciplinary action at any high school or college/university in connection to misconduct? ☐Yes ☐No

If yes, on a separate sheet of paper, explain each violation including: 1) brief description of incident 2) specific charge(s) made 3) disciplinary action taken 4) how the experience affected your life

ESSAY: TYPE OR WRITE (LEGIBLY) IN THE SPACE BELOW AN ESSAY DESCRIBING YOUR BACKGROUND, GOALS, MOTIVATION, HEALTH CAREER INTERESTS, AND REASONS FOR WANTING TO PARTICIPATE IN THIS PROGRAM. IF NECESSARY, EXPLAIN ANY UNUSUAL ASPECTS OF YOUR PREPARATION AND/OR APPLICATION (Use additional sheet(s) with your name and social security number if necessary).

I certify that the information submitted in this application is complete and true to the best of my knowledge.

Signature **Date**

By typing your name above you are authorizing this to be as binding as your signature.

APPLICATION DEADLINE IS MAY 1

Please Return To:
HCOP@UCHC.EDU

Supplemental materials should be mailed to:
Department of Health Career Opportunity Programs
UConn Health
Farmington, CT 06030-3920
attention: Tracey Higgins
860-679-8031
HIGGINS@UCHC.EDU
Website: HEALTH.UCONN.EDU/HCOP/